**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

RGV HEALTHCARE SYSTEM
BOX 6582
MCALLEN TX 78502

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-10-1292-01

**MFDR Date Received**
OCTOBER 10, 2009

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "$0.00 paid"

**Amount in Dispute:** $113.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual reviewed the bill and attached documentation, concluded the services provided were those ordinarily performed by the treating doctor, and declined to issue payment."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 4, 2009 | CPT Code 99361-W1<br>Medical Conference with Team | $113.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline.

**Issues**

Is the requestor entitled to reimbursement?

**Findings**

The respondent denied reimbursement for the case management services, billed with CPT code 99361 based upon reason code "892."

The respondent states in the position summary that "services provided were those ordinarily performed by the treating doctor, and declined to issue payment."

28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier 'W1' shall be added."

Review of the submitted documentation finds that the requestor submitted a Medical Team Conference & Plan of Care report that indicates the treating doctor, Rafael Lopez, MD met with the patient coordinator and Gary Molina to discuss plan of care. The documentation does not indicate that the patient coordinator or Gary Molina are healthcare providers, nor does it document their contribution in the case management activity; therefore, the requestor has not supported billing for the case management service.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 03/28/2014<br>Date |
|---|---|---|

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.